



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PALESTINE REGIONAL MEDICAL CENTER
5900 S LOOP 256
PALESTINE TX 75801-6958

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-09-7320-01

MFDR Date Received

March 27, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the injured employee... presented to the emergency room. The injured employee had an increase in pain with numbness, tenderness with decreased sensation to the knee. On a one to ten scale the patient had a pain level of an eight. The injured employee described the pain as aching and sharp. The injured employee was examined, given medication to treat the pain and inflammation and told to follow up with his primary care physician... the claim was denied as this provider not certified/eligible to be paid for this procedure, not treating doctor approved treatment. The claim was also denied that documentation does not support an emergency... I ask that you review the documentation and order the insurance carrier to pay for treatment provided on behalf of the injured employee."

Amount in Dispute: \$48.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is Texas Mutual's position that based on the medical records provided the treatment was not provided as part of an emergency and/or immediate post-injury medical care. The injured worker should have sought treatment through the treating doctor of records for continued treatment. The requestor has not provided documentation of an emergency as defined in TWCC Rule 133.1 (7)"

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2008	Emergency Room Visit	\$48.33	\$48.33

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 provides definitions of terms related medical billing and processing.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the

reimbursement guidelines for facility services provided in an outpatient acute care hospital.

4. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
5. 28 Texas Administrative Code §180.22 sets out the roles and responsibilities of health care providers.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - B7 – THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
 - 242 – NOT TREATING DOCTOR APPROVED TREATMENT.
 - B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
 - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MA BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
 - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
 - 724 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Were the disputed services required to be approved by the injured worker's treating doctor?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 724 – “NO ADDITIONAL PAYMENT AFTER RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK.” On October 29, 2009, the Division contacted Texas Mutual Insurance Company to clarify whether there was a contract in effect between the insurance carrier and the health care provider applicable to the disputed service. The insurance representative responded that the employer of the injured worker is a member of a network that processed the claim, but the provider of service is not a member of the network and no network discount or contractual agreement was applied to the services or in effect with the health care provider at the time the services were rendered. No other documentation was found to support a contractual agreement between the parties to this dispute. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Additionally, the insurance carrier denied disputed services with reason codes B7 – “THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE”, 242 – “NOT TREATING DOCTOR APPROVED TREATMENT”, B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED”, and 225 – “THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.” The respondent's position statement asserts that “the requestor has not provided documentation of an emergency as defined in TWCC Rule 133.1 (7).” 28 Texas Administrative Code §180.22(c)(1) requires that the treating doctor shall “except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers...” 28 Texas Administrative Code §133.2(3)(A) defines a medical emergency as “the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” The Division notes that it is not required that the patient actually be in jeopardy or suffer serious dysfunction, but rather what is required is that the patient manifest acute symptoms of such severity (including severe pain) that the health care provider, prior to treatment and without the benefit of hindsight, could reasonably expect the patient to be in jeopardy or to suffer serious dysfunction without further attention. Review of the submitted documentation finds that the injured worker presented to the emergency room after midnight with symptoms of numbness, decreased sensation, and pain intensity of 8 out of 10. The submitted documentation supports that the injured worker manifested symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious harm or jeopardy to the injured worker. As a medical emergency is supported, the disputed services were not required to be approved by the injured worker's treating doctor. The respondent's denial reasons are not supported.

3. This dispute relates to emergency room services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

Procedure code 99282 has a status indicator of V, which denotes clinic or emergency department visit paid under OPPS. This service is classified under APC 0613, which, per OPPS Addendum A, has a payment rate of \$83.67. This amount multiplied by 60% yields an unadjusted labor-related amount of \$50.20. This amount multiplied by the annual wage index for this facility of 0.887 yields an adjusted labor-related amount of \$44.53. The non-labor related portion is 40% of the APC rate or \$33.47. The sum of the labor and non-labor related amounts is \$78.00. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$78.00. This amount multiplied by 200% yields a MAR of \$156.00.
5. The total recommended payment for the services in dispute is \$156.00. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$156.00. The requestor is seeking \$48.33. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$48.33.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$48.33, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

<hr/>	Grayson Richardson <hr/>	May 24, 2012 <hr/>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.